

**Statement of  
American College of Surgeons  
to  
House Energy and Commerce Subcommittee on Health**

**presented by  
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Chair, of the ACS Patient Safety and Professional Liability Committee**

**RE: Patient Safety and Quality Initiatives**

**June 9, 2005**

*"The American College of Surgeons is dedicated to  
improving the care of the surgical patient and to  
safeguarding standards of care in an optimal and ethical  
practice environment."*

This mission statement of the American College of Surgeons can be found in the lobby of its building in Chicago. But this is not just a statement; elevating the standards and safety of surgical patient care are goals that the College has been putting into action since its founding in 1913.

My name is Dean Griffen, MD, FACS, and I am a general surgeon in private practice from Shreveport, Louisiana. I am pleased to be here today representing the American College of Surgeons and its 67,000 members. The College commends the House Energy and Commerce Subcommittee on Health for undertaking this important hearing. We are pleased to have this opportunity to present testimony detailing some of the surgical programs that have been developed to improve surgical patient safety and quality of care.

Patient safety and quality improvement depend on a composite of factors within the broad scope of the American health care system. In surgery, safety relies on the presence of competent and trained surgeons, on a "safe" institution, and on systems of good practices with which the surgical care is rendered.

**ACS History of Involvement in Quality Improvement Initiatives**

In 1918, the College initiated a Hospital Standardization Program in an effort to ensure a safe environment and effective system of care for surgical patients and others who are hospitalized. That program ultimately led to the establishment of what is known today as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This commitment continues through the participation of three College JCAHO commissioners, as well as through other programs and initiatives conducted by College committees and programs.

In 1922, the College established the multidisciplinary Commission on Cancer to set standards for high-quality cancer care. Today, the commission is comprised of more than 100 individuals representing more than 39 national professional organizations. Among other initiatives, the Commission on Cancer has established cancer program standards and conducted the accreditation of nearly 1,500 hospital cancer programs. It also provides clinical oversight for standard-setting activities and for the development and dissemination of patient care guidelines; and it coordinates national cancer site-specific studies on pattern of care and patient management outcomes through the annual collection, analysis, and dissemination of data for all cancer sites.

Shortly thereafter, the Committee on Fractures was formed, later to evolve into the Committee on Trauma, which develops the standards that most states employ to designate trauma centers. The trauma program also includes a National Trauma Data Bank that facilitates studies and the development of treatment guidelines for optimal care of injured patients.

While the American College of Surgeons has had a long history of involvement in patient safety and quality efforts, I would like to focus my testimony on some of our most recent initiatives, including:

- National Surgical Quality Improvement Program (NSQIP)
- Surgical Care Improvement Project (SCIP)
- ACS Bariatric Surgery Center Network Accreditation Program
- Committee on Emerging Surgical Technology and Education (CESTE)
- Surgical patient safety manual
- Closed claims analysis project
- National Surgical Time Out Day
- Various patient safety guidelines and principles

### **National Surgical Quality Improvement Program**

The National Surgical Quality Improvement Program (NSQIP) is the first nationally validated, risk-adjusted, outcomes-based program that has been demonstrated to measure and improve the quality of surgical care. The program was initially developed by the Department of Veteran's Affairs (VA) in the early 1990s, as an outgrowth of the National VA Surgical Risk Study. In the VA system, NSQIP had impressive results, with a 27 percent decline in post-operative mortality, a 45 percent drop in post-operative morbidity, a reduction in average post-operative length of stay from 9 to 4 days, and increased patient satisfaction. In 2001, the College developed its own NSQIP, which expanded the program to the private sector through a grant from the Agency for Healthcare Research and Quality.

The program employs a prospective, peer-controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, allowing valid comparison of outcomes

among the hospitals now in the program. Medical centers and their surgical staffs are able to use the data to make informed decisions about their continuous quality improvement efforts. The program involves the following key components:

- Data Collection
- Data Monitoring
- Validation Report Generation
- Data Analysis

Of particular interest to hospitals is the generation of a risk-adjusted, observed-to-expected outcome ratio for each center, which can be compared to other participating centers on a blind basis. Statistical analysis of the pre-operative data identifies risk factors and further analysis calculates the expected outcome for each hospital's patient population.

The NSQIP program involves a number of mechanisms to provide feedback to the participating hospitals and to the program as a whole. These mechanisms include annual data audits, site visits, and the sharing of best practices. This structured and careful feedback by program staff ensures the consistent reporting of data across sites and the rapid dissemination of information about successful surgical practices and about the environments that produce the highest quality of care.

So far, the College has expanded the NSQIP program to over 30 hospitals, including Partners HealthCare hospitals (the Harvard Medical School system), and applications are under development from dozens of others who want to be involved. In 2002, the Institute of Medicine named the NSQIP "the best in the nation" for measuring and reporting surgical quality and outcomes.

### **Surgical Care Improvement Project**

The College is one of the 10 organizations on the Surgical Care Improvement Project (SCIP) steering committee. SCIP is a national partnership of organizations dedicated to improving the safety of surgical care by reducing post-operative complications. Its steering committee reflects the range of public and private organizations that must work together to reduce surgical complications, and includes groups representing surgeons, anesthesiologists, perioperative nurses, pharmacists, infection control professionals, hospital executives, and others who are working to improve surgical patient care.

The program was initiated in 2003 by the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention. This summer, the SCIP partnership will launch a multi-year national effort to reduce surgical complications 25 percent by 2010.

SCIP quality improvement efforts are focused on reducing perioperative complications in the following four areas, where the incidence and cost of complications are significant:

- Surgical site infections
- Adverse cardiac events
- Venous thromboembolism
- Postoperative pneumonia

SCIP stresses that surgical care can be improved significantly through better adherence to evidence-based recommendations and by giving more attention to designing systems of care with thorough safeguards. Other evidence-based programs such as NSQIP, the National Nosocomial Infections Surveillance (NNIS) system, and the Medicare quality improvement organizations, have demonstrated this time and again. The College is proud to play a leadership role in the development of the SCIP performance measures, and our organization will continue to play a significant role in further developing SCIP initiatives.

### **ACS Bariatric Surgery Center Network Accreditation Program**

Recently, the College has developed a Bariatric Surgery Center Network (BSCN) Accreditation Program to foster high-quality care for patients undergoing bariatric surgery for morbid obesity. The program describes the necessary physical resources, human resources, clinical standards, surgeon credentialing standards, data reporting standards, and verification/approvals processes required for designation as a “bariatric surgery center.”

Severe obesity has reached epidemic proportions and because weight-reduction surgery provides an effective treatment for the condition -- and because the number of surgeons and hospitals providing this care has grown so quickly--the College decided recently to place high priority on establishing this new accreditation program. The College contracts with hospitals and outpatient facilities that agree to implement its facility and other resource standards by reporting outcomes data on all their bariatric surgery patients, by submitting to site visits, and by completing annual status reports. By reviewing existing studies and consulting with experts in the field, the College has developed standards, defined necessary resources, organized the means to collect data, and organized the processes for conducting site visits to accredit hospitals and outpatient facilities in order to improve patient safety within this accredited network.

### **Committee on Emerging Surgical Technology and Education**

Indeed, this whole area of disseminating new surgical technology into the broader world of surgical practice is one of great concern to the College generally. The College established its Committee on Emerging Surgical Technology and Education to study the implications of new technology and to suggest best methods of developing

policies that will accelerate education in this area and so protect surgical patient welfare.

Through the work of this committee, the College has approved a process by which its Fellows can be verified for the use of emerging surgical technologies. It also has created a voluntary verification process for surgeons performing ultrasound to ensure that these surgeons are, in fact, qualified and that their facilities and equipment are appropriate for medical application and that they meet and maintain quality standards.

### **Surgical Patient Safety: Essential Information for Surgeons in Today's Environment**

ACS has recently issued a patient safety manual titled Surgical Patient Safety: Essential Information for Surgeons in Today's Environment. This publication provides information and guidance for surgeons and others involved in surgical patient safety. It describes a variety of practical resources and provides a broad overview of key issues, such as the scientific basis of surgical patient safety.

Specifically, this manual analyzes the human factors, systems analyses, and processes affecting surgical patient safety. Issues such as decision-support, electronic prescribing, and error detection, analysis, and reporting are analyzed. Legal challenges for surgeon participation in patient safety activities are also reviewed. Broad error prevention methods such as the use of surgical simulation, educational interventions, and quality improvement initiatives are covered. In addition, the manual provides strategies for preventing wrong-site surgery and for safe blood transfusion and handling.

### **Closed Claims Analysis Project**

The College last year initiated an extensive analysis of closed general surgery malpractice claims in order to generate data that will help guide its patient safety educational efforts—and perhaps some research and standard setting efforts, as well. The Patient Safety and Professional Liability Committee, which I chair, is in the process of completing this pilot project to determine if we can replicate the success realized by the American Society of Anesthesiologists. The anesthesiology program, which has been in place for about 20 years, has led to engineering and practice changes that have had remarkable impact on reducing surgical patient injury and improving the quality of care.

The program promises to help us better identify and prioritize patient safety concerns. It will also allow the College to report to its members on the most common events leading to the most severe injuries, and help the surgical community develop the processes that will help correct these problems and avoid preventable maloccurrences.

### **National Surgical Time Out Day**

The College is a sponsor of the National Time Out Day, which highlights the JCAHO universal protocol and other initiatives that have been developed to reduce medical and surgical errors. All JCAHO accredited hospitals, ambulatory surgical centers, and office-based surgery facilities were required to adopt the universal protocol starting July 1, 2004. And, beginning last year, a coalition of physicians, hospitals, nurses, and other health providers partnered in a yearly coordinated effort to reduce medical errors in the future.

The surgical “timeout” is an opportunity before a surgical procedure begins for all members of the operating room team to review the case of the patient before them. Not only does the timeout provide an opportunity to identify inconsistencies and so prevent errors in the operating room, but by improving overall communication it helps empower all members of the team to continue the dialogue during the operation if things do not seem to be going according to plan.

### **Various Patient Safety Guidelines and Principles**

Over the past few years, there has been a noticeable increase in the number of invasive procedures being performed in the office setting. Recognizing that these settings are largely unregulated and very few have sought accreditation, the College called on the American Medical Association to work with it in convening a work group of relevant specialty societies and state medical associations to develop a set of principles for optimal office-based surgery.

In addition, the College, like others, has set forth guidelines for correct patient, correct site, and correct procedure surgery. In these guidelines, the College urges the surgical team to conduct a detailed final verification process on each of these crucial areas, and it calls for confirmation of the consent form by the patient or the patient’s designated representative. If a patient is scheduled for multiple procedures performed by different surgeons, all the items on the checklist are to be verified for each planned procedure. If any verification process fails to identify the correct site, the process must be immediately halted until verification is completely accurate.

This coming weekend, the College’s Board of Regents will be reviewing the draft of a new statement on “Prevention of Retained Foreign Bodies After Surgery.” These proposed guidelines provide for consistent application and adherence to standardized counting procedures and the use of X-ray, radiofrequency, and bar coded items during surgery.

### **Conclusion**

The College is proud of its many important innovations in quality improvement and patient safety, and it has plans for sponsoring additional programs. For example, we currently are conducting a pilot test of a hand-held case log system that surgeons in practice can use to record and report their operative experience. This system could, in turn, provide a quality benchmarking tool and help surgeons engage in practice-based

learning and quality improvement. We also are considering the development of new network accreditation programs according to the model set by our bariatric center program. We welcome initiatives by Congress that would create an environment that would facilitate, rather than hinder, the development of these private sector innovations and initiatives that hold such promise for improving the quality and safety of surgical patient care.

Thank you Mr. Chairman and Mr. Brown for allowing me to testify on behalf of our Fellows, and thanks to all the Members of the Subcommittee for their ongoing efforts to promote patient safety and quality.